LEVEL II: PASRR / MI
MENTAL HEALTH ASSESSMENT

State Form 47185 (R5 / 4-99) / BAIS 0036

Information contained herein is **CONFIDENTIAL** according to IC 16-14-1.6-8.

☐ PAS (PreAdmission Screening) ☐ New Mental Health Assessment ☐ Updated PAS	Give date of IPAS agency initial referral:	Give date returned to IPAS agency:	Send completed forms to: "LOCAL IPAS AGENCY"
☐ RR (Resident Review): ☐ Yearly RR ☐ Significant - Change RR ☐ "Missed" RR	Prior Level II done: ☐ Yes ☐ No ☐ Unknown If "Yes" complete for most-recent: (1) Check: ☐ PAS ☐ PAS Update ☐ Yearly RR ☐ Significant-Change RR (2) Give date of psychiatrist signature: _____ ☐ "Missed" RR		Send completed RR Check-list with RR Case(s) to: MS21 PASRR / MI Program, Room W454, P.O. Box 7083 Indianapolis, IN 46207-7083

Name of ☐ PAS applicant or ☐ NF resident:	Birthdate (*month. day. year*):	Age:	Sex: ☐ Male ☐ Female
Location where Level II completed (*name, address, city, state, ZIP code*) (*home or include name of facility or hospital*):		If in NF, date of initial admission:	
Name and address of CMHC or hospital completing Level II: *		Date of evaluation (*mo., day, yr.*):	

* This Level II assessment was completed by an entity which is not a nursing facility and has no direct or indirect affiliation with such facility. [P.L. 101-508, Sec. 408 (b)(1-8) and 42 CFR 483.106 (e)(3)]

I. PAS location of applicant (*check all that apply*):

- ☐ At own home / residence
- ☐ In hospital: ☐ Acute Care ☐ Non-Acute Care ☐ Psychiatric ☐ Non-Psychiatric
- ☐ In NF from home: ☐ APS ☐ Respite Stay
- ☐ Continued stay in NF beyond exempted hospital discharge
- ☐ Other: _____

II. Significant - Change RR purpose (*check all that apply*):

- ☐ Change in mental status WITHOUT hospitalization
- ☐ Change in mental status WITH hospitalization
  - ☐ In hospital (*No prior Level II*)
  - ☐ In NF (*Readmitted on basis of current Level II*)
- ☐ Other: _____

III. "Missed Level II": (*check one*)
☐ PAS ☐ Yearly RR ☐ Significant-Change RR

Private - pay: ☐ Yes ☐ No

Social Security number	Medicare number	Medicaid number

I. DRUG HISTORY

The PASRR / MI assessment process must provide a comprehensive drug history, including current and immediate past use of medications with particular attention to use of medications that could mask symptoms or mimic mental illness. [42 CFR 483.134 b(2)] The psychiatrist should review the medications for appropriateness and medication interaction.

LIST ALL CURRENT MEDICATIONS	DOSAGE / FREQUENCY	START DATE	REASON FOR PSYCHOTROPIC MEDICATIONS (*If Unknown, Explain*)

OPTION: Please see attached medication sheet. ☐ Yes ☐ No
SIGNIFICANT - CHANGE RR AND UPDATES ONLY: Reviewed current Level II: ☐ Yes ☐ No Significant changes: ☐ Yes ☐ No
INAPPROPRIATE REFERRAL (*Identified after assessment begun: Stop and complete Inappropriate Referral form.*)

PAST TWELVE MONTHS (*Major Psychotropic Drugs*)	DOSAGE / FREQUENCY	START / STOP DATES	REASON / PURPOSE FOR PSYCHOTROPIC MEDICATIONS

RR AND UPDATES ONLY: Medications reviewed: ☐ Yes ☐ No Any changes since last Level II: ☐ Yes ☐ No

Name of applicant	Social Security number	Date of birth

II. PSYCHOSOCIAL REPORT

The PASRR / MI assessment process must include a psychosocial evaluation of the person, including current living arrangements and medical support systems. [42 CFR 483.134 (b) (3)]

CURRENT LIVING ARRANGEMENT (*Brief description*) What has been this person's residence for the last several years? How long has this person lived in the nursing facility? What is this person's stated preference of living arrangement? Is it feasible? Explain. Add any other pertinent details deemed appropriate.

SUPPORT SYSTEMS (*Family, friendships, church, associations, etc.*) What emotional support does this person have? How extensive is the support system outside the NF? Where do they live? Who actively supports the person? Explain. For PAS cases, have you contacted the persons listed? Is there a legal guardian? Is the guardianship full or limited? Include names and addresses, if available.

MEDICAL SYSTEMS Identify this person's attending physician. (*Other pertinent medical professionals may be entered, as deemed necessary.*)

If the psychological evaluation is not conducted by a social worker, then a social worker's review and concurrence with pages 1 and 2 above is required and must be documented by a co-signature below. [42 CFR 483.134 (c)] Specify social worker's credentials: LSW, LCSW, BSW, and / or MSW.

Signature of evaluator	Professional credentials	Date (*month, day, year*)	Telephone number
Co-signature (*if needed*)	Professional credentials	Date (*month, day, year*)	Telephone number

III. PSYCHIATRIC HISTORY AND EVALUATION

The PASRR / MI process must be a comprehensive assessment. At a minimum, this assessment must address the following areas: complete psychiatric history for the past 24 months, including all hospitalizations and / or out-patient episodes; evaluation of intellectual functioning, memory functioning, and orientation; description of current attitudes and overt behavior; affect; suicidal or homicidal ideation; paranoia; and degree of reality testing (*presence and content of delusions*) and hallucinations. (42 CFR 483.134) Attach copies of all available discharge summaries dated within the past 24 months. You may summarize information from records. If unavailable, note and explain.

A. NAME OF TREATMENT LOCATION	DATE OF ADMISSION	DATE OF DISCHARGE	DIAGNOSIS (***Include current DSM code whenever possible***)	DISCHARGE SUMMARY

Is this individual currently receiving mental health services? ☐ Yes ☐ No

If "Yes", specify:

Name of applicant	Social Security number	Date of birth

B. MENTAL STATUS EVALUATION (*"WNL" means within normal limits. Check all box(es) that apply.*)

	WNL	VARIATIONS							
Appearance	☐	☐ Poor Hygiene	☐ Disheveled	☐ Inappropriate	☐ Bizarre	☐ Obese	☐ Thin/Emaciated	☐ Other (*Clarify below*)	
Attitude	☐	☐ Guarded	☐ Suspicious	☐ Uncooperative	☐ Belligerent	☐ Indifferent	☐ Manipulative	☐ Other (*Clarify below*)	
Motor Activity	☐	☐ Restless / Agitated	☐ Tremors / Tics	☐ Retarded				☐ Other (*Clarify below*)	
Affect	☐	☐ Constricted	☐ Stunted	☐ Flat	☐ Agitated	☐ Excited		☐ Other (*Clarify below*)	
Mood	☐	☐ Depressed / Sad	☐ Anxious	☐ Elated	☐ Hostile / Angry	☐ Euphoric	☐ Labile	☐ Other (*Clarify below*)	
Speech	☐	☐ Soft ☐ Loud	☐ Rapid ☐ Aphasic	☐ Slowed	☐ Delayed Responses	☐ Slurred	☐ Pressured	☐ Other (*Clarify below*)	
Thought Process	☐	☐ Circumstantial	☐ Tangential	☐ Loose	☐ Flight of Ideas	☐ Delusional	☐ Concrete	☐ Other (*Clarify below*)	
Thought Content	☐	☐ Paranoid	☐ Obsessional	☐ Poverty of Content		☐ Preoccupied with _____			
		☐ Hallucinations:	☐ Auditory	☐ Visual	☐ Other _____				
		☐ Suicidal:	☐ Ideations	☐ Intent	☐ Plans: Comments: _____				
		☐ Homicidal:	☐ Ideations	☐ Intent	☐ Plans: Comments: _____				
Orientation	☐	☐ Place	☐ Person	☐ Time	☐ Passage of Time		☐ Other (*Clarify below*)		
Memory	☐	☐ Recent	☐ Remote	☐ Selective	☐ Immediate		☐ Other (*Clarify below*)		
Judgment	☐	☐ Poor Impulse Control	☐ Questionable	☐ Maladaptive	☐ Co-Dependent	☐ Self-Destructive	☐ Other (*Clarify*)		
Insight	☐	☐ Has some insight	☐ Has very little insight		☐ Insight lacking	☐ Other (*Clarify below*)			
Intellect	☐	☐ Above Average	☐ Below Average		☐ Retarded	☐ Other (*Clarify below*)			
Cognition	☐	☐ Level of Consciousness	☐ Attention Span		☐ Abstract Thinking	☐ Calculation Ability	☐ Other (*Clarify*)		

C. NARRATIVE DESCRIPTION Give a narrative description of this person. Include any pertinent explanations of the MS evaluation checklist, above, or other behavioral problems identified. Additional pages / reports may be attached as needed. Address positive traits, strengths and weaknesses, and emotional needs. [42 CFR 483.128 (i)] **NOTE: This mental status description does not determine need for NF level of services.**

This person's current or past behavior presents a danger to self or others? ☐ Yes ☐ No (*If "Yes", explain.*)

Name of applicant	Social Security number	Date of birth

IV. SUMMARY OF ASSESSMENT FINDINGS

The Level II assessment must result in independent diagnosis(es) by the evaluator, supported by the data entered in the Level II document. When more than one (1) diagnosis is listed, list them by level of intensity with the **principal / primary** diagnosis first, etc. **ENTER CURRENT DSM CODE + DIAGNOSIS FOR EACH IDENTIFIED MI CONDITION.**

AXIS I: AXIS II: AXIS III: (*From medical records / NF chart*)

AXIS I from chart (optional):

DEFINITION OF "MENTAL ILLNESS": An individual is considered to have mental illness if he / she has a current primary or secondary diagnosis of a major mental disorder (*as defined in the current Diagnostic and Statistical Manual of Mental Disorders*) limited to schizophrenic, schizoaffective, mood (*bipolar and major depressive type*), paranoid or delusional, panic or other severe anxiety disorder; somatoform or paranoid disorder; personality disorder; atypical psychosis or other psychotic disorder (*not otherwise specified*); or another mental disorder that may lead to a chronic disability; and he / she does not have a concurrent predominant (*primary or principal*) diagnosis of senile or presenile dementia (*including Alzheimer's Disease or related disorder*) or any condition determined to be mental retardation / developmental disability (MR / DD). (*See Appendix C of the IPAS / PASARR program manual.*)

A. This individual ☐ **is** ☐ **is not mentally ill as defined above.**

DEFINITION OF "MI SPECIALIZED SERVICES": Specialized Services are defined as the implementation of an individualized plan of care developed under and supervised by a physician, provided by a physician and other qualified mental health professionals, that prescribes specific therapies and activities for the treatment of persons who are experiencing an **acute episode** of severe mental illness, which necessitates supervision by trained MH personnel. A nursing facility resident with mental illness who requires specialized services shall be considered to be eligible for the level of services provided in an institution for mental diseases (IMD) or an inpatient psychiatric hospital (*subject to Medicaid reimbursement requirements*).

B. This individual ☐ **is** ☐ **is not in need of mental health specialized services / inpatient psychiatric care (as defined above).**

C. SERVICES OF LESS INTENSITY THAN SPECIALIZED SERVICES: This individual needs the following mental health services, regardless of placement. (42 CFR 483.128) **CHECK ALL THAT APPLY**.

☐ Diagnosis Review / Update by NF / Hospital
☐ Dementia Work-Up
☐ MH Case Management Services
☐ Continue Current MH Services
☐ Yearly RR Required
☐ Psychiatric Evaluation
☐ Outpatient MH Services
☐ Individual / Group Therapy
☐ Partial Hospitalization / Day Treatment
☐ Further Evaluation of Medication Side Effects
☐ Medication Review
☐ Medication Adjustment
☐ Medication Monitoring
☐ Medication Administration
☐ Needs Further Review - Specify: _____
☐ Other - Specify: _____
☐ None of the above-listed services required at this time

Identify placement options which would meet the individual's needs. Check all viable options, regardless of current availability. NOTE: Recommendations do not constitute approval for such placement.
In my opinion, if nursing facility placement is not appropriate, the following option(s) may apply.

☐ State Hospital ☐ Other Residential - Specify: _____
CMHC Residential Program: ☐ Semi-Independent Living ☐ Supervised Group Living ☐ Alternative Family Living Program
☐ Other - Specify: _____

NOTE: The results of this assessment do not determine need for NF level of services.

IF INDIVIDUAL IS IN NF, AVAILABLE RESIDENT ASSESSMENT / MDS WAS REVIEWED: ☐ Yes ☐ No Comments: _____

Assessments are required under the minimum federal criteria for states to use in making preadmission screening and annual resident review determinations about admission to or continued residence in nursing facilities for individuals who have mental illness or mental retardation. (42 CFR 483.100-138)

Signature of Evaluator	Credentials	Date	Telephone number

I certify that I have reviewed the above report and concur with the findings. [42 CFR 483.134 (d)]

Signature of Psychiatrist	☐ Board certified ☐ Board eligible	Date	Telephone number